Maternity Care Clinical Escalation and Conflict of Opinion Guideline

This guidance does not override the individual responsibility of health professionals to make appropriate decision according to the circumstances of the individual patient in consultation with the patient and /or carer. Health care professionals must be prepared to justify any deviation from this guidance.

This guideline is for use by the following staff groups:

- Maternity staff including – Maternity Support Workers and Maternity Care Assistant (band 2 & 3), Midwives (all bands)
- Medical staff – Obstetric and Gynaecology Doctors (all grades), Anaesthetists (all grades)
- Theatre Staff – ODP, Scrub team, Recovery team

Lead Clinician(s)

Laura Veal	Clinical Director, Consultant Obstetrician
Jane Wardlaw	Assurance and Compliance Midwife
Joanna Clarke	Retention Midwife
Daisy Austin	Guideline Midwife
Approved by *Maternity Governance* ……. on:	16th August 2024
Review Date: This is the most current document and should be used until a revised version is in place	16th August 2027

Key amendments to this guideline

Date	Amendment	Approved by:
August 2024	New document Minor amendments may be made to this document following publishing. Highlighted in yellow	MGM

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1) Introduction

In the majority of cases, teams work together, communicate well and escalate effectively to achieve positive outcomes and birth experiences for women and babies.

However, it is in the rare but devastating cases that we see common themes of poor communication, failed escalation, or ineffective teamwork. This is particularly so when individuals, teams, or the whole system are fatigued or under stress, often due to a high workload.

At times of immense pressure, we often see a rise in **incivility**, which in turn has the potential to impact adversely on patient safety. The interventions outlined in this guidance are replicated from the RCOG Escalation toolkit (Each Baby Counts 20??) are therefore designed to promote **excellence** in communication, teamwork, and escalation at all times, by providing standardised frameworks for all staff to use.

Clear escalation processes are necessary to reduce neonatal and maternal harm as well as reducing staff confusion. This guideline ensures the appropriate channels are followed to achieve safe and timely care for women, birthing people and their babies by the most appropriate member of the team. It also assists in resolution of any conflict of clinical opinion which may arise between health practitioners involved in the care of a maternity client and supports staff to 'speak up with their concerns.
Organisations need formal written documents which communicate standard organisational ways of working. These help bring consistency to day-to-day practice and can improve the quality of work and increase the successful achievement of objectives

2) Scope of this guideline

This guidance is intended to support escalation and resolution of differences of opinion in any clinical situation and should be read in conjunction with the relevant clinical practice guidance for the specific situation (these will be named within the document).

- To reduce delays in escalation by improving the response escalation and action taken
- To standardise the use of safety critical language
- To reduce feelings of hierarchy, creating a supportive environment which empowers staff of all levels to speak up when they identify deterioration or a potential mistake
- To promote a culture of respect, kindness and civility amongst staff members, normalising positive feedback and saying thank you to each other
- To improve the ways in which we listen to women and birthing people

3) Guideline standards and procedures

3.1) Essential Principles

- Time frame

Whether the situation allows time for full discussion, or the patient needs time critical care will influence the response taken. In every situation the health professionals involved should be empowered to speak up about any concerns they have.

- Multidisciplinary (MDT) approach

An open discussion should take place with key members of the multidisciplinary team (MDT) which focuses on providing safe care for the patient.

DAY – Anaesthetist, Band 7 Delivery Suite Co-ordinator, Unit Co-ordinator (223), Matron of the day, Obs/gynae - SHO, REG, CONS, Speciality leads (if required), Critical outreach (if required)

NIGHT – Anaesthetist, Band 7 Delivery Suite Co-ordinator, Unit Co-ordinator (223), Obs/gynae - SHO, REG, CONS, Manager on Call, Speciality leads (if required), Critical outreach (if required)

- Be Objective

Differences in opinion can cause frustration and an emotional response. It is important to take a holistic view of the situation, using assessment tools where appropriate and communicating concerns clearly.

- Involve the patient

In all situations it is best practice to sensitively involve the patient in decisions about their care. Ensuring all the principles of fully informed choice and shared decision making.

- Communicate effectively

The key to escalating and resolving concerns is effective communication.

- Documentation

A summary should be documented in the patient's medical records including: the concerns raised; the points discussed and who was involved; and a clear agreed plan.

- Incident Reporting (DATIX)

The difference of clinical opinion should be reported formally if unresolved or required further escalation via the Datix System, so it can be reviewed independently which supports learning both for the professionals involved and the clinical team.

- Consultant non-attendance

In the circumstances of a consultant on call not attending when expected against the RCOG standards then a Datix must be completed. Listings of circumstances of consultant attendance are in Appendix 1.

3.2) Informed Choice

Rather than dictating a 'one size fits all' rule, guidelines should provide information about different treatment options and their benefits based on current evidence.

Health professionals have a responsibility to effectively interpret the evidence-based recommendations of guidelines and ensure shared decision making with patients. Where there is a conflict of clinical opinion, health professionals should have open and honest discussions with the patient.

This promotes shared decision making and enables the patient's preferences to be included in any discussions about their care.

3.3) Tools to Support Objectivity

There are many tools which support healthcare professionals to be factual when raising their concerns. For example, Early Warning Scores and the Sepsis 6 pathway.
Assessment of the patient's condition with a recognised tool should be used in conjunction with professional judgement when communicating concerns.

Clinical practice guidelines relevant to the situation can also be useful, along with current research or national resources (for example NICE or speciality specific bodies), in presenting your concerns.

Click on the link to access trust guidelines and policies WAHNHST Key Documents

3.4) Effective communication

- SBAR

The SBAR communication tool is designed to structure information sharing between healthcare professions (NHSE 2021).

The SBAR tool also supports professionals who are less confident or experienced in escalating their concerns through the need to state their recommendations. Healthcare professionals do not work in isolation and can ask for support and advice if they are unsure about any aspect of escalating their concerns.

Communication will be most effective if it includes the professionals who have the difference of opinion. If it is not possible to leave the patient, the SBAR tool can support escalation with accurate information.

Refer to the SBAR Handover of care in antenatal, intrapartum and postnatal periods for further information – SBAR Handover in the antenatal, intrapartum and postnatal periods

- RCOG Teach or Treat – refer to Appendix 2
- RCOG AID – refer to Appendix 3
- RCOG Team of the shift – refer to Appendix 4

3.5) Evaluation

Ongoing clinical evaluation is an integral part of patient care. Assessing the patient should continue in line with the relevant clinical guidance to review the effectiveness of the agreed plan with further MDT discussion as required.

3.6) Reflection and Learning

Conflicts of clinical opinion can feel stressful resulting in reflection after the event. It is important that we learn as individuals and as a team. Support available includes Professional Midwifery Advocates, clinical supervisors (Doctors) and Medical Education Team.

There may be a need for a formal debrief session to support team members to understand each other's rationale for decision making during challenging clinical situations. Learning from differences in opinion may also result in the need to update clinical practice guidelines.
It may be that a professional recognises a difference of opinion on reflection following an event. It is never too late to have an open clinical discussion where any concern is highlighted.

If you do not feel you have been treated with respect when you have shared your concerns, speak to your line manager/Matron or Educational supervisor. Any delay in care should be reported on DATIX.

3.7) Escalation Process

When required, the appropriate person to escalate to will depend on the health professional's role and the clinical situation.

Inpatients Escalation

Refer to Appendix 5 To gain knowledge of agreed Summary process for escalation
Refer to

Appendix 6 for specific job roles within the escalation process

Outpatients/Community/Day Assessment Units

Refer to Appendix 7 To gain knowledge of agreed Summary process for escalation
Refer to Appendix 8 for specific job roles within the escalation process

Triage
Ensure the BSOTS escalation process is adhered to as outlined in the BSOTS guideline Link

4) Conflict of Clinical Opinion

The majority of situations will be resolved quickly at the time of the disagreement; however, they may arise when: -

- Endorsed clinical guidelines are not being followed
- Concerns for woman/ birthing persons welfare held by one practitioner are not acknowledged by another
- Intervention is deemed necessary by one practitioner but not by the other
- There is a disagreement as to a diagnosis or
- There is disagreement as to the appropriate management of a situation

Where a conflict of clinical opinion arises, during the course of maternity care, the clinicians involved should follow the conflict escalation flow chart in Appendix 8 until there is an agreed management plan in place

People you can escalate to for support in resolving differences of clinical opinion include (but not exclusive to): Appendix 9

Note: Resolution is not about winning an argument; it is about understanding each other's clinical opinions and agreeing a safe plan of care for the patient. It may be that both points of view offer safe care options resulting in an opportunity to discuss choices with the patient.

5) Education and Training

The importance of escalating clinical concerns for patient safety is embedded within WAHT maternity training programs (PROMPT, Physiological CTG, Mandatory maternity training)

Core principles of Human Factors and Civility have been including in the Worcestershire Acute training needs analysis for Midwives, MSW's/ MCA's, Obstetricians and Anaesthetists since 2022 as per the mandate from Ockenden 2022 and NHS resolution CNST MIS scheme.

6) Support for psychological safety

6.1) Civility and Respect

The following link will describe our Staff Promise

Civility and Respect (sharepoint.com)

6.2) Freedom to Speak up Portal

The following link provides a confidential platform and all concerns raised.

Home Page - Freedom to Speak Up (worcsacute.nhs.uk)

Click on link below to review the Freedom to Speak up Policy

http://whitsweb/KeyDocs/KeyDocs/DownloadFile/3236

6.3) Behavioural charter

WAHT has made a commitment to zero-tolerance approach towards, bullying, harassment, discrimination, violence or aggression of any kind towards staff, patients or visitors across all our sites and services

Trust Behavioural Charter - what to do if you've experienced or witnessed poor behaviour (sharepoint.com)

6.4) Wellbeing Matters Hub

Through our Wellbeing Matters pin wheel we aim to offer a 'one-stop shop' to a range of support for colleagues that includes advice and signposting on your psychological, physical, social and financial wellbeing, as well as helpful information on our civility and respect programme in the Trust, and our equality, diversity and inclusion commitments. There is also a range of information on the staff benefits available to you as an employee of the Trust. Find out more Wellbeing Matters Hub - Home (sharepoint.com)

To access further information for psychological wellbeing including mental health first aiders follow the link to our staff wellbeing booklet: Supporting Our NHS Staff booklet [nhs.sharepoint.com]

To access urgent 24/7 counselling support from the Network of Support Services (NOSS) call 01978 780479

6.5) Retention midwife

The purpose of the role of Retention Midwife is to support staff clinically and psychologically to remain in post with an optimal wellbeing status. To contact this service if required call 07354168653. All of your communications are confidential and personalised planning is provided around any support needed.

6.6) Maternity and Neonatal Safety champions

Maternity and Neonatal safety champions play a central role in ensuring that mothers and babies continue to receive the safest care possible by adopting safe practice. Should clinical escalation affect this, safety champions can support in the process of improving these circumstances. Any concerns can be communicated by emailing;

wah-tr.maternityneonatalsafetychampions@nhs.net

6.7) Professional Midwifery Advocate

A Professional Midwifery Advocate (PMA) supports midwives as well as women/ birthing people and families/ units with the aim of improving the wellbeing of both parties.

Contact

6.8) Management of Dignity at work – Building Working relationships

In situations where conflicts/ working relationship include incivility or behavioural concerns use the link below which includes Dignity at work process tool kit and all templates required to follow the WAHT human resources pathway.

http://whitsweb/KeyDocs/KeyDocs/Sub_Webpage/1786?persist=True

Appendix 1
Obstetric & Anaesthetic Consultant presence in Delivery Suite/ Obstetric theatre

ON CALL CONSULTANT OBSTETRICIAN PRESENCE

Consultant Obstetrician presence mandated in Delivery Suite / Obstetric theatre

- Eclampsia
- Maternal collapse (such as massive abruption, septic shock)
- Caesarean section: placental praevia/abnormally invasive placenta
- Caesarean section <28/40
- Caesarean section for BMI >50
- PPH >2L where the haemorrhage is continuing and Massive Obstetric Haemorrhage protocol has been instigated
- Return to theatre
- Early warning score protocol or sepsis screening tool that suggests critical deterioration where HDU / ITU care is likely to become necessary
- In the event of high levels of activity e.g a second theatre being opened, unit closure due to high levels of activity requiring obstetrician input
- Premature twins <30/40
- 4th degree tear
- Unexpected intrapartum stillbirth
- Team debrief requested
- If requested to do so
- If asked to attend due to management disagreements between different clinical staff
- In rare obstetric situations –e.g. Unexplained maternal fits, trial of assisted delivery of a stillbirth, shoulder dystocia where all the routine manoeuvres fail

Discussion with Consultant Obstetrician mandated

- Preterm labour < 28weeks (to ensure appropriate management plan & consideration of transfer to tertiary unit
- Consultant involvement in the management and support of IUDs
- Maternal death within the unit
- Difficulty delivering baby

ON CALL CONSULTANT ANAESTHETIST PRESENCE

Consultant Anaesthetist presence mandated in Obstetric theatre

- Failed Intubation
- Maternal Cardiac Arrest
- Eclampsia
- Amniotic Fluid Embolism

Discussion with Consultant Anaesthetist mandated

- Symptomatic PET with abnormal biochemistry or haematology
- Morbid obesity (BMI over 45)
- Anticipated difficult intubation
- Other rare complex medical problems
- Abnormal Placentation
- Total Spinal Anaesthesia
- Major on-going haemorrhage over 1.5 Litres

Situations in which the consultant MUST ATTEND unless the most senior doctor present has documented evidence as being signed off as competent.

If competent the senior doctor and the consultant should decide in advance if the consultant should be INFORMED prior to the senior doctor undertaking the procedure.

- Vaginal Breech Delivery
- Any patient with an EBL >1.5litres and ongoing bleeding
- Review of labour management and delivery of twins/ higher order pregnancy twin delivery
- Trial of instrumental birth
- Caesarean section: full dilation, BMI>40, transverse lie, CS <32/40
- Vaginal twin birth
- 3rd degree tear repair
- To confirm intrauterine fetal demise
- Acute medical / surgical illness in women requiring senior multidisciplinary input

Inform on call consultants of safety huddles to ensure multidisciplinary involvement when unit escalation policy implemented

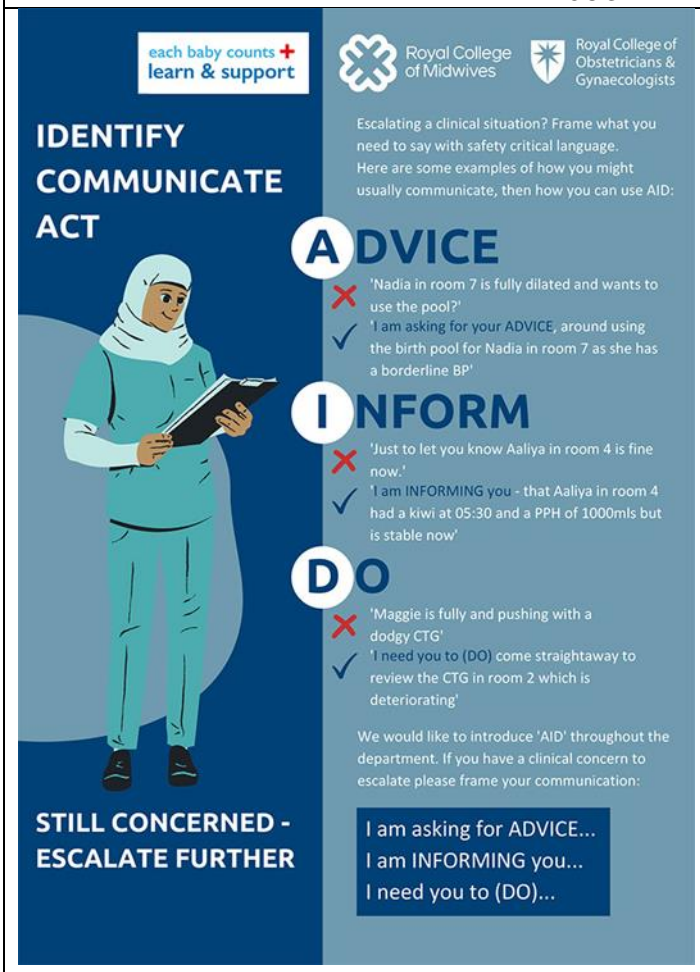
Obstetric & Anaesthetist Consultant Presence in Delivery Suite - Updated January 2023

Appendix 2

RCOG Teach or Treat	
	Teach or Treat is a communication strategy which encourages a discussion about the clinical situation being escalated: initiating a kind, quick and respectful response. It is both about exploring ways to escalate and reducing hierarchical decision making. It promotes a collaborative understanding about the unravelling clinical situation, learning and understanding from everyone's perspectives, and encourages respect for the opinion of others. *For a demonstration video please scan the QR code*
The aim of Teach or treat	When to used Teach or treat
• Promote respectful conversations between staff members so that junior members of the team are not afraid to be unsure, be wrong, or escalate concerns. • Promote shared understanding of a clinical situations from different clinicians' perspectives • Put the woman at the heart of the decision making and information giving • Identify when escalation has taken place	• When implemented in units around the country, it was most widely used when interpreting CTGs. However, it can be used in any clinical situation. • On ward rounds • When performing "fresh eyes" if there is disagreement between the two clinicians • When escalating clinical concerns

• Promote a flattened hierarchy, a culture of learning and of mutual respect • Empower all members of the team to respectfully challenge if they think another member may be making a mistake	• In CTG / intrapartum care teaching
What do women think?	
• Women who witnessed the conversations received reassurance and better understandings of their own situation, whilst describing the conversations as respectful.	

Appendix 3

<table>
<tr><th colspan="2">RCOG AID</th></tr>
<tr><td> 
</td><td>Effective clinical escalation requires clear, succinct communication with the right person at the right time. It also requires receiving the correct response at the right time, often in a complicated, evolving clinical situation. AID is as a clear and simple communication tool which initiates escalation conversations using 3 simple phrases:

“I am asking you for Advice”,

“I am Informing you” and

“I need you to Do…”

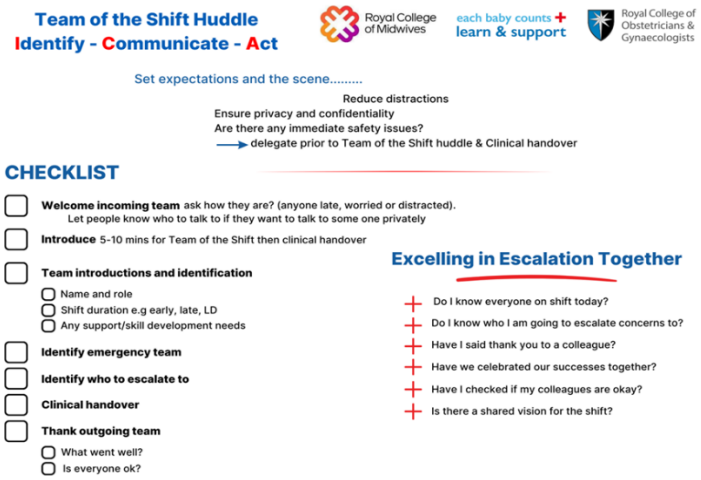
For a demonstration video please scan the QR code</td></tr>
<tr><td>The aim of AID</td><td>When to use AID</td></tr>
<tr><td>Clearly identify when escalation is taking place
Elicit a time critical response, reducing delays
Help prioritisation for clinicians who may receive multiple escalations within any given shift (band 7 midwifery co-ordinators, consultants)
Empower junior staff</td><td>At the outset of all escalation conversations between ALL members of the MDT
Particularly helpful when escalating to non-resident clinicians (usually consultants) and during periods of high activity</td></tr>
</table>

Appendix 4

<table>
<tr><th colspan="2">RCOG Team of the Shift</th></tr>
<tr><td> 
</td><td>Teams delivering intrapartum care are large, complex and involve many professional and hierarchical roles.
It is not uncommon to be unfamiliar with some members of the team in any given shift. However, optimal communication and clinical escalation, particularly in rapidly emerging time critical situations relies on effective teamwork and leadership. It also requires high levels of trust, an understanding of each other's job roles, and a shared mental model of the team's workload.

For a demonstration video please scan the QR code</td></tr>
<tr><td>The Aim of Team of the Shift</td><td>When to use Team of the shift</td></tr>
<tr><td>Identify all the staff on shift that day, including job role and length of shift
Identify the team leaders, including those who will be escalated to
Flatten hierarchies by giving everyone a voice and encouraging first name introductions
Support staff by creating psychological safety, encouraging them to raise concerns and speak up
Identify anyone in the team who may need additional support that day
Identify learning needs for trainees and students</td><td>At the start of every shift, particularly in complex intrapartum care areas
Prior to clinical handover
The gold standard would be for all members of the multidisciplinary team to be present, (including representatives from neonatal and theatre staff), but differing shift patterns between staff groups often prevent this. In addition, many units lack the physical infrastructure to accommodate such a large group</td></tr>
</table>

• Create a positive workplace culture by thanking staff and celebrating successes • Foster a culture of kindness and civility • Eliminate cultures of criticism, including "toxic handovers" • Foster a sense of teamwork, mutual respect, and create a shared mental model of the team's workload, priorities, and potential challenges that shift	*of people, although this is increasingly overcome using technology*.



Team of the Shift Huddle
Identify - Communicate - Act

Royal College of Midwives — each baby counts + learn & support — Royal College of Obstetricians & Gynaecologists

Set expectations and the scene.....
Reduce distractions
Ensure privacy and confidentiality
Are there any immediate safety issues?
→ delegate prior to Team of the Shift huddle & Clinical handover

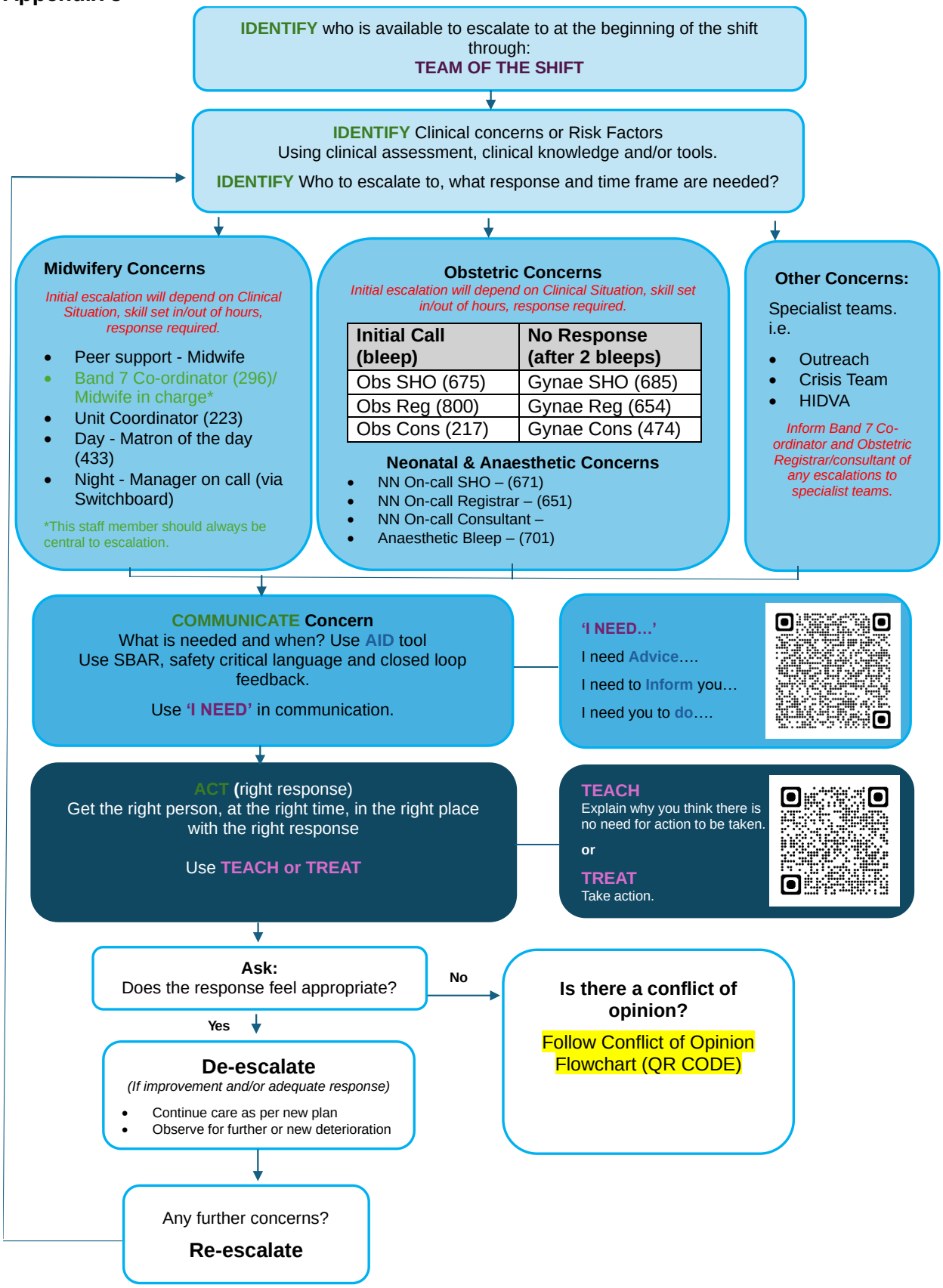
CHECKLIST

- ☐ **Welcome incoming team** ask how they are? (anyone late, worried or distracted).
  Let people know who to talk to if they want to talk to some one privately
- ☐ **Introduce** 5-10 mins for Team of the Shift then clinical handover
- ☐ **Team introductions and identification**
  - ☐ Name and role
  - ☐ Shift duration e.g early, late, LD
  - ☐ Any support/skill development needs
- ☐ **Identify emergency team**
- ☐ **Identify who to escalate to**
- ☐ **Clinical handover**
- ☐ **Thank outgoing team**
  - ☐ What went well?
  - ☐ Is everyone ok?

Excelling in Escalation Together

- + Do I know everyone on shift today?
- + Do I know who I am going to escalate concerns to?
- + Have I said thank you to a colleague?
- + Have we celebrated our successes together?
- + Have I checked if my colleagues are okay?
- + Is there a shared vision for the shift?

Appendix 5

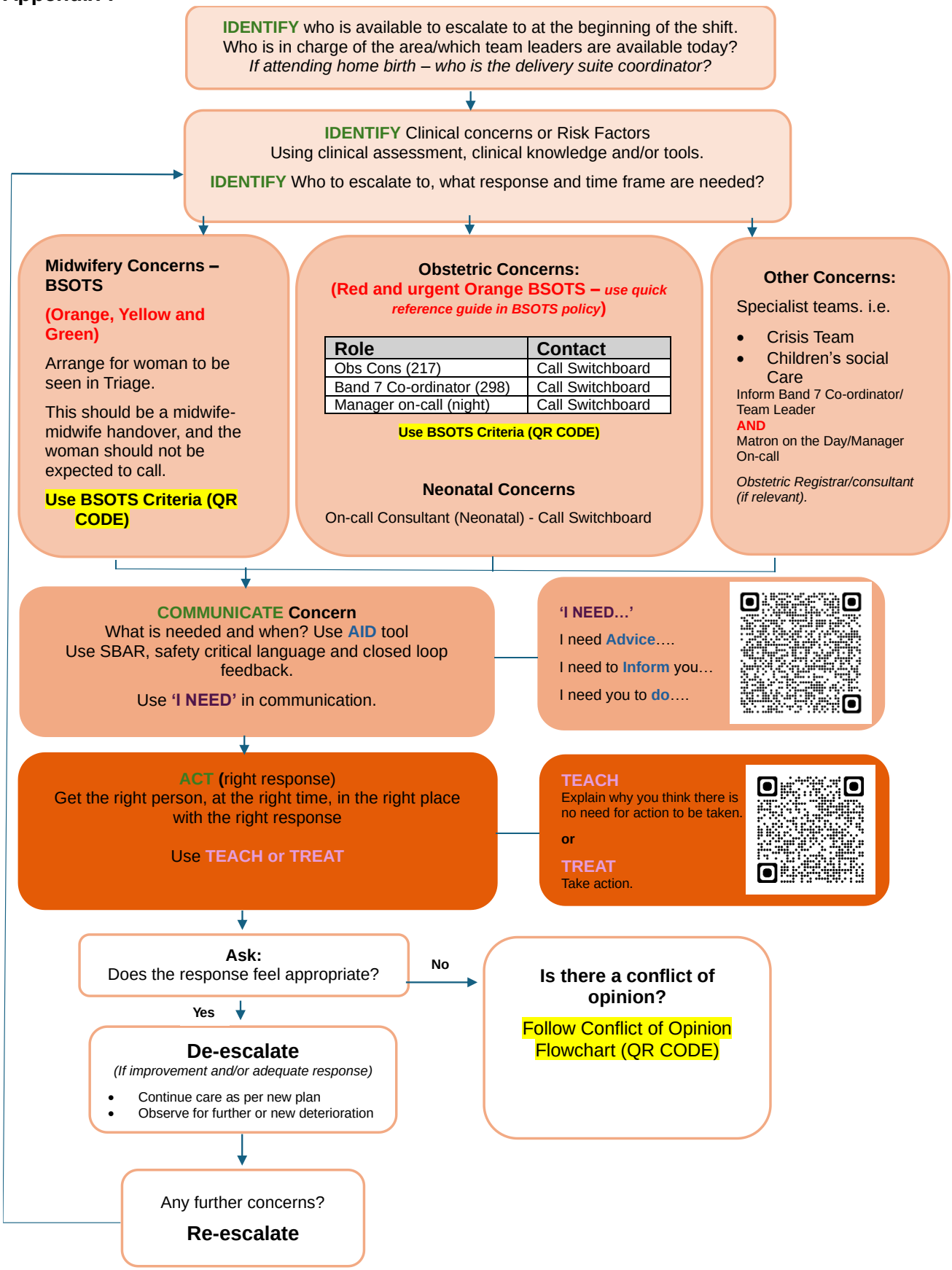

IDENTIFY who is available to escalate to at the beginning of the shift through:
TEAM OF THE SHIFT
IDENTIFY Clinical concerns or Risk Factors
Using clinical assessment, clinical knowledge and/or tools.
IDENTIFY Who to escalate to, what response and time frame are needed?
Midwifery Concerns
Initial escalation will depend on Clinical Situation, skill set in/out of hours, response required.
Peer support - Midwife
Band 7 Co-ordinator (296)/ Midwife in charge*
Unit Coordinator (223)
Day - Matron of the day (433)
Night - Manager on call (via Switchboard)
*This staff member should always be central to escalation.
Obstetric Concerns
Initial escalation will depend on Clinical Situation, skill set in/out of hours, response required.
Initial Call (bleep)
No Response (after 2 bleeps)
Obs SHO (675)
Gynae SHO (685)
Obs Reg (800)
Gynae Reg (654)
Obs Cons (217)
Gynae Cons (474)
Neonatal & Anaesthetic Concerns
NN On-call SHO – (671)
NN On-call Registrar – (651)
NN On-call Consultant –
Anaesthetic Bleep – (701)
Other Concerns:
Specialist teams. i.e.
Outreach
Crisis Team
HIDVA
Inform Band 7 Co-ordinator and Obstetric Registrar/consultant of any escalations to specialist teams.
COMMUNICATE Concern
What is needed and when? Use AID tool
Use SBAR, safety critical language and closed loop feedback.
Use 'I NEED' in communication.
'I NEED…'
I need Advice….
I need to Inform you…
I need you to do….
ACT (right response)
Get the right person, at the right time, in the right place with the right response
Use TEACH or TREAT
TEACH
Explain why you think there is no need for action to be taken.
or
TREAT
Take action.
Ask:
Does the response feel appropriate?
No
Is there a conflict of opinion?
Follow Conflict of Opinion Flowchart (QR CODE)
Yes
De-escalate
(If improvement and/or adequate response)
Continue care as per new plan
Observe for further or new deterioration
Any further concerns?
Re-escalate

Worcestershire Acute Hospitals NHS Trust

Appendix 6

Inpatients Services		
Member of team	**Bleep**	**Reasons for Escalation (Examples)**
SHO (FY1 / FY2, ST1 / ST2)	760	· Prescribing TTO's
		· Cannulation and Blood Cultures
		· Triage reviews (if appropriate)
		· Post Section discharges
		· Review of Antibiotics/ blood results
Registrar/ Clinical Fellow (ST 3-9)	800	· Clinical decision making
		· Prescribing and prioritising induction of Labour
Consultant	217	· Refer to attendance of consultant RCOG listing (Appendix 1)
		· Confirmation of IUD
		In situation of conflict of opinion
Advanced Clinical Practitioner	789	· Triage
Anaesthetist	701	· Anaesthetic emergency
		Or in situation of conflict of opinion (if circumstances apply)
Band 7 Co-ordinator	298	· Initial Fetal/ maternal monitoring concerns
		· Transfer required from Meadow Birth Centre/ Antenatal/ Postnatal/ Triage
Unit Co-ordinator	223	· Band 7 Co-ordinator not available and clinical emergency
		· Co-ordination of Intra-uterine transfers (In & Out unit), Consultant has final decision
		See core responsibilities of 223 - link
DAY - Matron of the day	Switch Board	· De-escalation of situations ie Staffing/ Patients
		In situation of conflict of opinion
NIGHT - Manager on call	Switch Board	· De-escalation of situations ie Staffing/ Patients
		· Care outside of guidance
		· Significant incidents
		In situation of conflict of opinion (out of hours)
		Link to policy staffing escalation
Specialist teams	Switch Board	· Called as appropriate to the clinical circumstance

Appendix 7

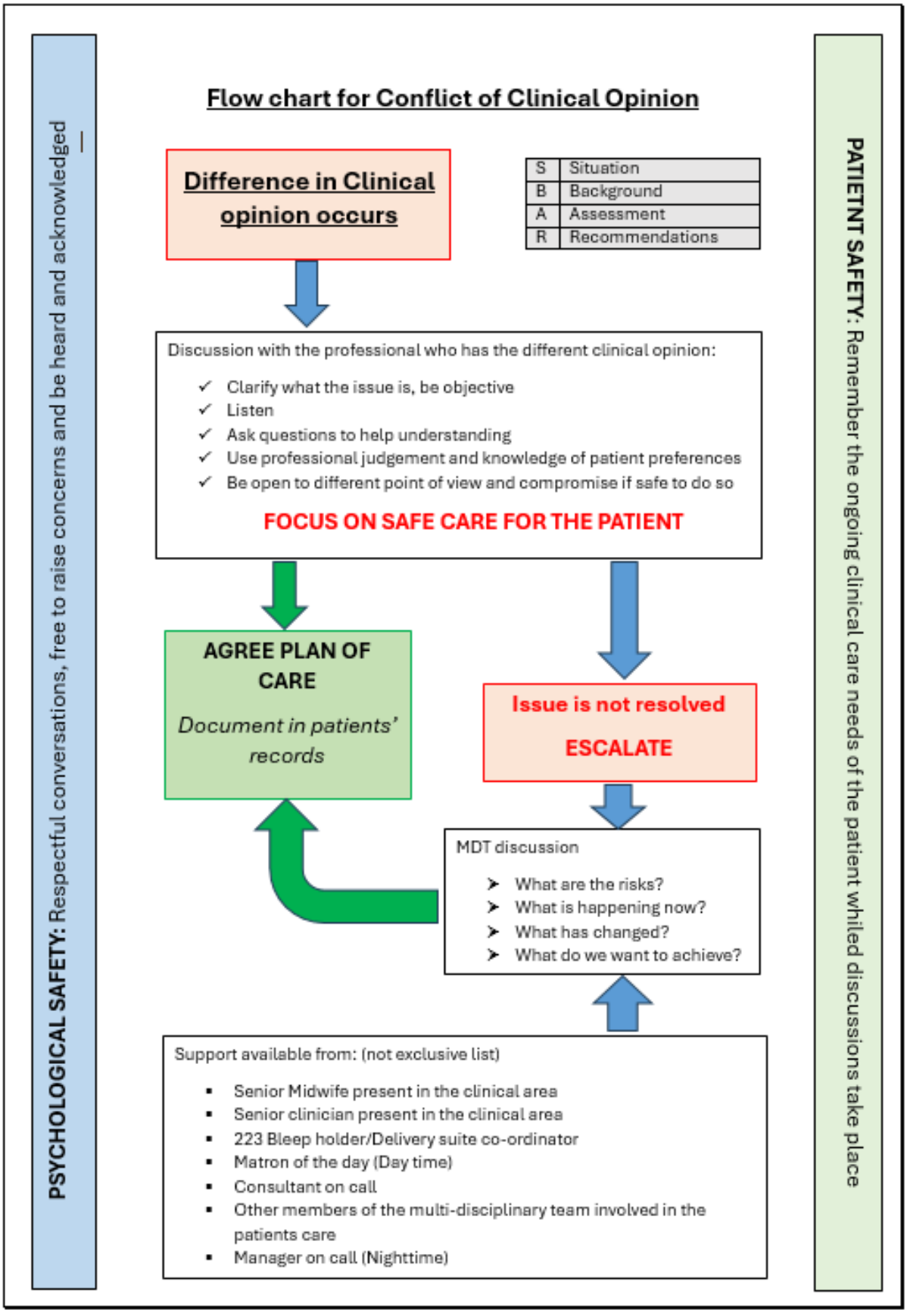

IDENTIFY who is available to escalate to at the beginning of the shift.
Who is in charge of the area/which team leaders are available today?
If attending home birth – who is the delivery suite coordinator?
IDENTIFY Clinical concerns or Risk Factors
Using clinical assessment, clinical knowledge and/or tools.
IDENTIFY Who to escalate to, what response and time frame are needed?
Midwifery Concerns – BSOTS
(Orange, Yellow and Green)
Arrange for woman to be seen in Triage.
This should be a midwife-midwife handover, and the woman should not be expected to call.
Use BSOTS Criteria (QR CODE)
Obstetric Concerns:
(Red and urgent Orange BSOTS – use quick reference guide in BSOTS policy)
Role | Contact
Obs Cons (217) | Call Switchboard
Band 7 Co-ordinator (298) | Call Switchboard
Manager on-call (night) | Call Switchboard
Use BSOTS Criteria (QR CODE)
Neonatal Concerns
On-call Consultant (Neonatal) - Call Switchboard
Other Concerns:
Specialist teams. i.e.
Crisis Team
Children's social Care
Inform Band 7 Co-ordinator/ Team Leader
AND
Matron on the Day/Manager On-call
Obstetric Registrar/consultant (if relevant).
COMMUNICATE Concern
What is needed and when? Use AID tool
Use SBAR, safety critical language and closed loop feedback.
Use 'I NEED' in communication.
'I NEED…'
I need Advice….
I need to Inform you…
I need you to do….
ACT (right response)
Get the right person, at the right time, in the right place with the right response
Use TEACH or TREAT
TEACH
Explain why you think there is no need for action to be taken.
or
TREAT
Take action.
Ask:
Does the response feel appropriate?
No
Is there a conflict of opinion?
Follow Conflict of Opinion Flowchart (QR CODE)
Yes
De-escalate
(If improvement and/or adequate response)
Continue care as per new plan
Observe for further or new deterioration
Any further concerns?
Re-escalate

Appendix 8

Outpatients / Community/ Day Assessment Unit Services		
Member of team	**Bleep**	**Reasons for Escalation (Examples)**
Registrar/ Clinical Fellow (ST 3-9)	800	· Clinical decision making
		· Prescribing and prioritising induction of Labour
Consultant	217	· Refer to attendance of consultant RCOG listing (Appendix 1)
		· Confirmation of IUD
		In situation of conflict of opinion
Advanced Clinical Practitioner	789	· Triage
Anaesthetist	701	· Anaesthetic emergency/ advise
		Or in situation of conflict of opinion (if circumstances apply)
Triage/ Band 7 Co-ordinator	298	· Initial Fetal/ maternal monitoring concerns
		· Transfer required - Ambulance admission
Unit Co-ordinator	223	· Band 7 Co-ordinator not available and clinical emergency
		· Co-ordination of Intra-uterine transfers (In & Out unit), Consultant has final decision
		See core responsibilities of 223 - link
DAY - Matron of the day	Switch Board	· De-escalation of situations ie Staffing/ Patients
		In situation of conflict of opinion
NIGHT - Manager on call	Switch Board	· De-escalation of situations ie Staffing/ Patients
		· Care outside of guidance
		· Significant incidents
		In situation of conflict of opinion (out of hours)
		Link to policy staffing escalation
Specialist teams	Switch Board	· Called as appropriate to the clinical circumstance

Worcestershire Acute Hospitals NHS Trust

Appendix 9



Appendix 10

Psychological Safety

Professional did not feel respected or listened to when discussing difference of opinion

Seek Support from;

- Your link Manager
- Professional Midwifery Advocates
- Maternity/ Neonatal Safety Champions
- Clinical Supervisor
- Education Team
- Freedom to Speak up Guardian
- NB - Not an Exclusive list

It is important that your concerns are shared with the professional who did not treat you with respect. This could either be through a mediated conversation between the 2 parties or escalated on your behalf

Clinical Safety

Professional still has safety concerns despite escalating concerns (see appendix joint appendix)

Seek Support from someone independent of the discussions which have taken place. Their role is to mediate further discussion supporting professionals to agree a way forward.

Refocus on the best outcome for the woman and birthing person.

Support available from ;

- Manger on call
- Independant consultant (Clinical Director/Second on call)
- Head/Duputy Director of Midwifery
- NB - Not an exclusive list

Note: the on-call consultant has overall clinical and legal accountability. This is particularly relevant where a clinical decision needs to be made quickly.

References

[You should include external source documents and other Trust documents that are related to this Policy]

Contribution List

Contribution List

This key document has been circulated to the following individuals for consultation;

Designation
All Members of the Maternity Guidelines Group
All Members of Maternity Governance

This key document has been circulated to the chair(s) of the following committee's / groups for comments;

Committee
Maternity Guidelines Meeting
Maternity Governance Meeting – Chairs Approval